requested of respondent on June 27, 2005 any statistical evidence of the frequency of treating physician consultative examinations. Instead, respondent routinely employs "key consultative examination providers" (See 20 CFR 404.1519s(e)), who tend to develop a relationship with the Administration, in preference to treating physicians. *Social Security Law and Practice*[3] at Sect. 37:74, p.63 pointedly notes that these consultative physicians "are employed and paid by the government for the purpose of defending against a disability claim...."

As more than four million Social Security Disability claims were decided in 2004,[4] the scope and import of the cases at bar can hardly be overstated. Petitioners urge that this constitutes an important question of federal law that should be settled by the Supreme Court.

SSA also introduced regulations to require that SSA recontact the treating physician by telephone or mail in an attempt to resolve perceived discrepancies prior to rejecting his findings in favor of those of a non-treating physician consultant (20 CFR 404.1512(e)(1)). "Enforcing the Agency's Duty to Recontact Physicians" was one of the three "Hot Topics in Federal Court Litigation" at the November 2004 conference of the National Organization of Social Security Claimants' Representatives. There is a split between the Circuits on this issue, which must be resolved. The Fifth Circuit, in the cases below, held that failure to comply with this regulation constitutes harmless error. But in the Eighth Circuit cases of *Bowman v. Barnhart*, 310 F.3d 1080 (8th Cir. 11/20/2002) and *O'Donnell v. Barnhart*, 318 F.3d 811 (8th Cir. 02/07/2003), ¶32, and in the Tenth Circuit cases of *White v. Massanari*, 287 F.3d

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[3] Travers, Timothy E., ed., *Social Security Law and Practice*, Clark, Boardman, Callaghan (Deerfield, IL., 1993).

[4] U. S. Office of Disability Programs, January 2005

903 (10th Cir. 2001) and *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004), the courts of appeals remanded for failure to comply with 20 CFR 404.1512(e)(1). This conflict between the Circuits must be resolved.

A third such regulation requires SSA to consider the factors of 20 C.F.R. 404.1527(d)(2), regarding the nature of the competing treating and non-treating physician opinions, prior to rejecting the findings of the treating physician. Again, the Circuits are split. The Fifth Circuit, in the cases below, found failure to comply with this regulation to be harmless error. The Second Circuit in *Clark v. Commissioner of Social Security*, 143 F.3d 115, 118 (2d Cir. 1998), the Sixth Circuit in *Wilson v. Commissioner of Social Sec.*, 378 F.3d 541 (6th Cir. 2004), and the Tenth Circuit, in *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004) and *Goatcher v. U.S. Department of Health & Human Servs.*, 52 F.3d 288, 290 (10th Cir. 1995) all found failure to consider the factors of 20 C.F.R. 404.1527(d)(2) to be reversible error. This conflict between the Circuits must also be resolved.

In the cases at bar, the Fifth Circuit Court of Appeals found that failure to comply with 42 USC 423(d)(5)(B)and implementing regulations constituted "harmless error." But the Sixth Circuit, in *Wilson v. Commissioner of Social Sec.*, 378 F.3d 541 (6th Cir. 2004) addressing the same argument, found that failure of respondent to follow its own procedural regulations, particularly 20 C.F.R. 404.1527(d)(2), constitutes deprivation of a "substantial right" and is reversible error. This division between the Circuits must also be resolved.

Finally, the Fifth Circuit, in the cases below, found that the obligation to develop the record can be shifted to claimants, presumably even unrepresented claimants. The Tenth Circuit, in *White v. Barnhart*, 287 F.3d 903, 908 (10th Cir. 2001) and *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004) expressly rejected this argument. This conflict between the Circuits must also be resolved.

Thus, at least four Circuits are in conflict on matters that directly affect millions of disabled claimants each year. Accordingly, petitioners respectfully urge that it is appropriate that the Supreme Court resolve these issues, which are so important to millions of disabled Americans each year.

The Congress has instructed the Social Security Administration in the use of treating physicians by amending the Act. Only the Judiciary can enforce the will of the Congress.

1. Whether the court of appeals erred in holding that, in Social Security Disability claims, failure of the Social Security Administration to comply with 20 C.F.R. 404.1527(d)(2) and implementing regulations, which require that the Commissioner "make every reasonable effort to obtain from the individual's treating physician...all medical evidence, including diagnostic tests, necessary in order to properly make such determination," constitutes harmless error.

Prior to 1984, the Social Security Act contained provisions for consultative examinations by non-treating physicians but no restrictions on their use.

In 1982, Respondent was engaged in an accelerated program of review of eligibility for recipients of Social Security Disability benefits. The program resulted in an avalanche of complaints to Congress about the methods of evaluation. In the 97th Congress, the Senate Finance Committee heard such complaints as that of Ethel A. Kage, of Reed City, Michigan, whose husband had died, she felt, partially as a result of improper termination of his benefits due to deficiencies in the system of disability evaluation. Her main complaint was that the Social Security Administration "ignored" the findings of the physician who had treated her husband for a number of years and instead relied upon the findings of a consultative physician

who had performed a brief exam.[5]

Also submitted into the Congressional Record was a letter from Sen. John Heinz, Chairman of the Special Committee on Aging, which stated:

> Psychiatric consultants have publicly complained that the brief time allotted to them to evaluate the patient's condition is altogether insufficient to reach a valid conclusion about the individual's mental health, and the American Psychiatric Association (APA) has pointed out that the consultations are too cursory and too brief to be of value.[6]

Senator Cohen noted that the Act did not even provide the deference to the treating physician accorded in workers' compensation cases.[7]

In 1984, the Senate finally passed SB 476, subsequently including its provisions as an amendment to HR 3755, which it passed 96-4. The provisions of that amendment subsequently became 42 USC 423(d)(5)(B).

Petitioners urge that the proper interpretation of that amendment includes the following:

1. Consultative exams are designed to be used by SSA only where there is conflicting medical evidence that it is necessary to resolve in order to make an eligibility determination. Instead, in many cases, they are in fact ordered routinely, **used as a counterpoint to the report of the treating physician**, and relied upon almost exclusively.

2. The amendment directs SSA to give great credence to

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[5] Hearing before the Committee on Finance of the United States Senate, Ninety-Seventh Congress, Second Session, August 18, 1982, p.54.

[6] Hearing before the Committee on Finance of the United States Senate, Ninety-Seventh Congress, Second Session, August 18, 1982, p.17.

[7] *Ibid.*

the findings and reports of a beneficiary's treating physician who more often than not has lived closely with that subject's disabilities and through his/her hands-on experience has developed a more thorough knowledge of the illness than the consultative examiners who may give no more than 30 minutes for the evaluation.

3. SSA complains that treating physicians too often provide mere opinion without the necessary test results or specific medical findings upon which the disability examiner can make the necessary determination. This amendment is telling SSA to ask the proper questions of the treating physician so it can elicit a helpful response. If there are tests to be conducted and scientific assessments made of an individual's functional capabilities, SSA should work with the treating physician to get those answers. Under the provisions in this amendment, we should witness far fewer consultative exams and more thorough and factually based reports by treating physicians.

Should the Court be inclined to question this interpretation, it should first note that the foregoing was taken, almost verbatim and specifically including the phrase "used as a counterpoint to the report of the treating physician," from the remarks of the lead author[8] of S.B. 476, Sen. Carl Levin, to the full Senate in urging the amendment just prior to its passage.[9]

This is now the law of the land. 42 USC 423(d)(5)(B) provides:

> In making any determination the Commissioner of Social Security shall make **every reasonable effort** to obtain from the individual's treating physician (or other treating health care provider) all medical evidence, including diagnostic test, necessary in order to properly

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[8] With Sen. William S. Cohen of Maine

[9] See Appendix "L" for the full text.

> make such determination, prior to evaluating medical evidence obtained from any other source on a consultative basis. (Emphasis supplied)

That is, respondent's obligation to a claimant is such that it must try **every** reasonable means to base its determination on the findings and opinions of the treating physicians until it can be fairly said that it would be un**reasonable** to ask it to make further **effort**. Only then can respondent consider findings of a non-treating physician. Claimant urges this to be clearly the most insightful means of determining a claimant's true condition. But, wise or unwise, prudent or imprudent, that is the law this Court now interprets.

In *Schisler v. Heckler*, 787 F.2d 76 (2nd Cir. 1986), the Second Circuit noted non-acquiescence with the newly enacted "treating physician rule"and directed respondent to expeditiously "state in relevant publications...that adjudicators...are to apply the treating physician rule of this circuit." In response, respondent offered a proposed Social Security Ruling (SSR) that was rejected by the Second Circuit in *Schisler v. Bowen*, 851 F.2d 43 (2nd Cir. 1988). The Second Circuit offered instead an approved SSR.

Finally, the Social Security Administration enacted in 1991 new regulations on consultative and treating physicians essentially adopting the proposals of the Second Circuit. Included among these are 20 CFR 404.1512 and 404.1527(d)(2).

20 CFR 404.1512(e) and (f) provide that the consultative examination shall be ordered only if still necessary **after recontacting the treating physician**. The relevant portions of these regulations read as follows:

> (e) Recontacting medical sources. When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a

> decision. To obtain the information, we will take the following actions.
> (1) We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. **We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques.**
>
> . . .
>
> (f) Need for consultative examination. If the information we need is not readily available from the records of your medical treatment source, or we are unable to seek clarification from your medical source, we will ask you to attend one or more consultative examinations at our expense. See 404.1517 through 404.1519 for the rules governing the consultative examination process. Generally, **we will not request a consultative examination until we have made <u>every reasonable effort</u> to obtain evidence from your own medical sources**.
>
> . . .
>
> **We will not evaluate this evidence until we have made <u>every reasonable effort</u> to obtain evidence from your medical sources**. (Emphasis supplied)

Counsel for Petitioners has repeatedly obtained remands from the district courts over the past decade when ALJs have failed to comply with the criteria of 20 CFR 404.1512(e)(1). All of these cases have been unreported, though a number of them were summarized in *Lewis v. Chater*, 1996 WL 43111 (E.D. La. July 31, 1996) (No.Civ.A.95-3402) (attached to plaintiff's Fifth Circuit brief in Fink).

The Fifth Circuit took its first step toward enforcement of 42 USC 423(d)(5)(B) and implementing regulations in *Newton v. Apfel*, 209 F.3d 448 (5th Cir. 2000). More recently, in the Eighth Circuit cases of *Bowman v. Barnhart*, 310 F.3d 1080 (8th Cir. 11/20/2002) and *O'Donnell v. Barnhart*, 318 F.3d 811 (8th Cir. 02/07/2003), ¶32, and in the Tenth Circuit cases of *White v. Massanari*, 287 F.3d 903 (10th Cir. 2001) and *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004), the courts of appeals remanded for failure to comply with 20 CFR 404.1512(e)(1).

The amendment to the Act and the subsequent regulations do not remove from the ALJ the authority to make the final evaluation of the evidence. It merely provides procedures to ensure that every reasonable effort is made to turn to the treating physician(s) to obtain the medical evidence upon which the decision is based. When the treating physician(s) cannot provide that information, a consultative examination is ordered, employing a treating physician if he is qualified and willing (20 CFR 404.1519h) or a non-treating physician if he is not.

But the consultative examination cannot be ordered until the treating physician is contacted in an attempt to obtain the necessary information, including an explanation of perceived discrepancies.

And, as noted, 42 USC 423(d)(5)(B) and 20 CFR 404.1512(f) prohibit even considering evidence from a consulting examiner until "every reasonable effort" is made to obtain the requisite information from the treating physician through recontact as provided in 20 CFR 404.1512(e)(1).

Respondent has regularly ignored the regulations and the mandate of 42 USC 423(d)(5)(B), and, presumably, the ALJs are not instructed in their implementation. Otherwise, it is unlikely that the ALJ in *Passaro v. Barnhart*, E.D.LA. No.04-1300, would have openly expressed his disdain for the Reform Act as follows:

Q Well, you present me with a difficult case, ma'am. Okay. I -- there are doctors here who say that you know basically, you're totally incapacitated.

A And well, I do agree.

Q And then I have a consultative exam from Dr. Forette, which basically says, he can't find very much wrong with you at all and you need to go to work.

. . .

A I mean this is three doctors to one.

Q Well -- yeah. That's true. So maybe it should -- I'm not sure I'm supposed to evaluate on the vote basis.

A Well, yeah. I mean these doctors have known me since the wreck happened. One of the doctors has been my doctor since I had been 19 years old. And he knows me.

Q Well, hat's (sic) true.

A And I'm to somebody just to -- I sit around and it's very, it's boring. And it's --

Q The only problem I have to discover with these, these -- when the treating physicians give these kind of summary opinions. Is that a lot of times they want the best for their patient. And they're basically become patient advocates and they strew (sic) things in favor of the patient. Which is I think natural for them to do. But what it means is that I don't get an objective assessment from them. Because they want to you know, see the -- see their patient get what they want. Which is natural. Because they're the patient. But I, what I have to decide is, is whether this is an objective medical opinion, based on medical records that support it or whether this is basically patient advocacy. If you understand what I mean.

A I did not understand that. What did you mean?

Q What I mean is, is that I got a lot of treating doctors who will basically give reports that are not

accurate because they want to do a favor.

A Keep me coming back.

Q Well, they want to do a favor for their, their patient. And if their patients want it, then they'll say it whether it's true or not.

That ALJ rejected the findings of the treating physicians. The United States District Court for the Eastern District of Louisiana rejected the recommendation of the U.S. Magistrate and remanded the case for rehearing, which is now pending. Nevertheless, the foregoing demonstrates that the ALJs do not feel constrained by 42 USC 423(d)(5)(B).

In the cases at bar, accepting the findings of the treating physicians would have resulted in a finding of disability. But, in rejecting those findings, the respondent:

1. Ordered consultative examinations without first attempting to recontact the treating physician to obtain the needed information, in violation of 20 CFR 404.1512(e)(1);

2. Ordered consultative examinations without soliciting the treating physician to perform the examination, in violation of 20 CFR 404.1519h;

3. Not only considered, but also relied upon, the findings of consulting examiners without first recontacting the treating physicians to resolve a perceived conflict between office notes and findings on a medical assessment form and to determine the basis for the treating physician's endorsement of symptoms which the ALJ considered not supported by clinical findings, in violation of 20 CFR 404.1512(f);

4. Rejected the findings of the treating physicians without recontacting them as required by 20 CFR 404.1512(e)(1); and

5. Rejected the findings of the treating physicians without considering the criteria of 20 C.F.R. 404.1527(d)(2).

All of which violate, as well, the instructions and intent of 42 USC 423(d)(5)(B).

Finally, the ALJ's decision in Rochester offered no reasons whatever for rejecting Dr. Holden's findings. In

Goodley v. Harris, 608 F.2d 234, 236 (5th Cir. 1979) the Court of Appeals held that an ALJ may not arbitrarily choose to ignore uncontroverted medical evidence. And 20 C.F.R. 404.1527(d)(2) states, "We will always give good reasons in our notice of determination or decision for the weight we give your treating source's opinion." By failing to provide any reasons, much less "good reasons," for rejecting Dr. Holden's findings, the ALJ committed reversible error.

It is difficult to imagine in the instant cases how the SSA could have controverted the treating physician rule and the attendant regulations more than it did. In each case, had the appropriate law and regulations been followed, it is likely, not just possible, that a different decision would have resulted. Had appropriate weight been afforded the opinions of the treating physicians, a different decision definitely would have resulted.

Yet the Fifth Circuit held that failure to comply with the Act and regulations constitutes harmless error, stating, "Because Fink and Rochester were afforded the opportunity to supplement their respective records with additional medical reports from their treating physicians, we hold that any procedural errors committed by the commissioner were harmless and did not affect Fink's or Rochester's substantial rights. See Morris v. Bowen 864 F.2d 333, 335 (5th Cir. 1988)."

But a claimant cannot know how to supplement the record to satisfy an ALJ's reservations about treating physician opinions unless and until the ALJ articulates them. And in the rare event that the ALJ does provide sufficient specificity in his decision to afford supplementation, is the claimant constrained to submit the additional evidence to the Appeals Council and wait some two years for redress? And, generally, is not such a holding clearly inconsistent with Congressional intent?

The Fifth Circuit puts the "harmless error" rule in perspective in cases such as *Frank v. Barnhart*, 326 F.3d 618 (5th Cir. 2003) and *Anderson v. Sullivan*, 887 F.2d 630, 634 (5th Cir. 1989) when it explained, "The major policy underlying the

harmless error rule is to preserve judgments and to avoid waste of time."

In *Morris*, claimant had been unable to work around machinery. A vocational expert subsequently found a number of jobs claimant could perform, two of which, "lawn care" and "grass cutting," required work around machinery. However, the remainder of the jobs found were within the limitations imposed by the ALJ, so that it did not matter whether the claimant could work on lawns. The Court stated that:

> [P]rocedural perfection in administrative proceedings is not required. This court will not vacate a judgment unless the substantial rights of a party have been affected. The procedural improprieties alleged by Morris will therefore constitute a basis for remand only if such improprieties would cast into doubt the existence of substantial evidence to support the ALJ's decision.

Thus the acceptance by the ALJ of improper jobs did not prejudice Morris in any way, as the ALJ correctly found other jobs he could perform. That is hardly equivalent to the situation in the case at bar. The total abandonment of the implementing regulations of and the provisions of 42 USC 423(d)(5)(B) constitutes much more than a bare lack of "procedural perfection." It constitutes a flagrant violation of a claimant's right to have his or her treating physician provide the evidence on which a determination of eligibility for disability benefits is based, a right conferred by the same body that drafted the Social Security Act, the U. S. Congress.

Moreover, if failure to comply with the regulations can be corrected by allowing opportunity to supplement the records, why does HALLEX I-5-310 Attachment IV provide:

> 10. How should the Appeals Council respond to a challenge to the admissibility of a CE report obtained at the hearing level without first making every reasonable effort to obtain the needed information from the

> claimant's medical source(s)?
> As indicated above, we are precluded from evaluating a CE report obtained pursuant to § 404.1512(f)/416.912(f) until the needed information is received from the claimant's medical source(s) or every reasonable effort has been made to obtain it. **If a decision shows that the ALJ evaluated a CE report before the needed information was received or every reasonable effort had been made, there is an error of law, and the Appeals Council will grant review to take appropriate corrective action.** (emphasis supplied)

Counsel for Petitioners has obtained a number of remands from the Appeals Council for failure to comply with 20 CFR 404.1512(e)(1) and related regulations. *In re Jerry Edwards* (attached to Plaintiff's brief in Fink), is selected as representative, as there was a conflicting opinion from a non-treating source. In *Edwards*, the Appeals Council remanded, saying:

> In accordance with 20 CFR 404.1512(e), when the reports from a treating physician do not contain all of the necessary information to support the ultimate assessment provide(d) by the physician, the treating source must be recontacted and asked to provide a new report, a more detailed report, or copies of additional existing medical information. While unreasoned or undocumented opinions by treating physicians cannot be determinative, section 404.1512(e) provides that an effort must be made to obtain evidence from treating sources whose opinions lack the appropriate documentation or reasoning.

If, in the opinion of respondent's own Appeals Council, the availability of supplementation of the record does not obviate the need for remand, then, by respondent's own decisions, failure to make every reasonable effort obviously

constitutes reversible error.

The comments in the Federal Register accompanying the promulgation of 20 CFR §§ 404.1512 and 404.1527 clarify the Commissioner's intention to make recontact with the treating source ***mandatory***, rather than permissive, in order to afford special status to treating sources:

> Recontact with treating sources to complete the case record and to resolve any inconsistencies in the evidence is one of the principal provisions of this set of rules. See Sections 404.1512(d) and 416.912(d) of these final regulations. Far from being restrictive, the intent of these rules is to **require** such contacts.56 Fed. Reg. 36950-1 (August 1, 1991) (Emphasis added).

If the right to have the opinions of treating physicians serve as the basis for a determination of disability is not a "substantial right," then the Fifth Circuit panel is correct, and the U.S. Congress is wrong, for Congress considered the right sufficiently substantial to amend the Social Security Act to assure that right to claimants. To the best of petitioners' knowledge, this is the only occasion on which Congress felt strongly enough about a question of evidence to Amend the Social Security Act. They amended it to ensure that decisions are based on information from treating physicians and specifically not from non-treating examiners used as a "counterpoint" to the report of the treating physician.

The Fifth Circuit also distinguished the cases at bar from *Newton v. Apfel*, 209 F.3d 448 (5th Cir. 2000) by noting that *Newton* was a case in which there were no contradictory opinions from non-treating physicians. Of course, petitioner noted that distinction in Fink's original brief (p.38) and urged the expansion of *Newton* to the cases at bar. But there is no basis for that distinction, and the legislative history demonstrates that it was precisely cases in which a non-treating examiner was "used as a counterpoint" to the treating physicians for which the Act was amended.

Moreover, the Fifth Circuit does not deny the applicability of the Act and regulations to the cases at bar, so that it, in fact, does expand the *Newton* decision to the instant cases. Thus, if the availability of supplementation of the record did not render the error harmless in *Newton*, how can it be harmless in the cases at bar?

There is also a split in the Circuits as to the need for an ALJ to address the factors of 20 C.F.R. 404.1527(d)(2) (See *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004)), ¶30, in which the Tenth Circuit remanded for failure to address the factors of 20 C.F.R. 404.1527(d)(2))

Additionally, the *Newton* court said:

> Several federal courts have concluded that an ALJ is required to consider each of the § 404.1527(d) factors when the ALJ intends to reject or give little weight to a treating specialist's opinion. See *Clark v. Commissioner of Social Security*, 143 F.3d 115, 118 (2d Cir. 1998); *Goatcher v. U.S. Department of Health & Human Servs.*, 52 F.3d 288, 290 (10th Cir. 1995); *Dwyer v. Apfel*, 23 F. Supp. 2d 223, 228 (N.D.N.Y. 1998); *Amidon v. Apfel*, 3 F. Supp. 2d 350, 355-56 (W.D.N.Y. 1998); *McDonald v. Apfel*, No. CA 3-97-CV-2035R, 1998 WL 159938, *8 (N.D. Tex. Mar. 31, 1998). This court now similarly holds that an ALJ is required to consider each of the § 404.1527(d) factors before declining to give any weight to the opinions of the claimant's treating specialist. The ALJ failed to perform this analysis, which should be conducted on remand.

The foregoing makes no distinctions between cases wherein there are or are not contrary opinions by consulting physicians, nor has anyone proposed any basis for such a distinction, nor do other Circuits make such distinction. How would the ability to supplement the record render failure to consider the factors of 20 C.F.R. 404.1527(d)(2) harmless? And how does the ability to supplement the record render

harmless the failure to employ a treating physician for a consultative examination?

Respondent offered the same "harmless error" argument in *Wilson v. Commissioner of Social Sec.*, 378 F.3d 541 (6th Cir. 2004). Because petitioners consider the opinion to be dispositive, much of it is quoted herein:

> It is an elemental principle of administrative law that agencies are bound to follow their own regulations. As the Ninth Circuit well summarized in applying this principle:
>
> [30] The Supreme Court has long recognized that a federal agency is obliged to abide by the regulations it promulgates. See *Vitarelli v. Seaton*, 359 U.S. 535, 545 (1959); *Service v. Dulles*, 354 U.S. 363, 372 (1957); *Accardi v. Shaughnessy*, 347 U.S. 260, 267 (1954). An agency's failure to follow its own regulations "tends to cause unjust discrimination and deny adequate notice" and consequently may result in a violation of an individual's constitutional right to due process. Where a prescribed procedure is intended to protect the interests of a party before the agency, "even though generous beyond the requirements that bind such agency, that procedure must be scrupulously observed." *Vitarelli*, 359 U.S. at 547 (Frankfurter, J., concurring); see also Note, Violations by Agencies of Their Own Regulations, 87 Harv. L. Rev. 629, 630 (1974) (observing that agency violations of regulations promulgated to provide parties with procedural safeguards generally have been invalidated by courts).
>
> [31] *Sameena, Inc. v. United States Air Force*, 147 F.3d 1148, 1153 (9th Cir. 1998) (parallel citations and circuit court citations omitted). Consistent with this principle, courts have remanded the Commissioner's decisions when they have failed to articulate "good reasons" for not crediting the opinion of a treating

source, as §§ 1527(d)(2) requires. See, e.g., *Newton v. Apfel*, 209 F.3d 448, 456 (5th Cir. 2000); *Snell*, 177 F.3d at 134; see also *Halloran*, 362 F.3d at 33 ("We do not hesitate to remand when the Commissioner has not provided ''good reasons' for the weight given to a treating physician's opinion and we will continue remanding when we encounter opinions from ALJ's that do not comprehensively set forth the reasons for the weight assigned to a treating physician's opinion.").

...

[34] In particular, the ALJ...did not explain its application of the factors listed in 20 C.F.R. §§ 404.1527(d)(2) to determine the weight given to DeWys's opinion. Reversal is therefore required.

[35] The ALJ's failure to give "good reasons" for not crediting DeWys does not constitute harmless error, notwithstanding the district court's reasoning and the Commissioner's argument on appeal....Echoing the district court, the Commissioner contends that, assuming for argument's sake that the ALJ misread DeWys's opinion, this mistake qualifies as harmless error. The Commissioner asserts that the ALJ's rejection of DeWys's opinion is supported by substantial evidence, as the ALJ "could" have relied on evidence in the record--namely, Wilson's testimony and the opinions of two consulting physicians, which, according to the Commissioner, contradict DeWys's opinion–to reject the opinion.

[36] The argument is not persuasive in the context of this case. A court cannot excuse the denial of a mandatory procedural protection simply because, as the Commissioner urges, there is sufficient evidence in the record for the ALJ to discount the treating source's opinion and, thus, a different outcome on remand is unlikely. "[A] procedural error is not made harmless

simply because [the aggrieved party] appears to have had little chance of success on the merits anyway." *Mazaleski v. Treusdell*, 562 F.2d 701, 719 n.41; see also *Ingalls Shipbuilding, Inc. v. Dir., Office of Workers' Comp. Programs*, 102 F.3d 1385, 1390 (5th Cir. 1996). **To hold otherwise, and to recognize substantial evidence as a defense to non-compliance with §§ 1527(d)(2), would afford the Commissioner the ability the violate the regulation with impunity and render the protections promised therein illusory.** The general administrative law rule, after all, is for a reviewing court, in addition to whatever substantive factual or legal review is appropriate, to "set aside agency action ... found to be . . . without observance of procedure required by law." Administrative Procedure Act, 5 U.S.C. §§ 706(2)(D) (2001).

[37] Our conclusion is consistent with the statement in *Connor v. United States Civil Service Commission*, 721 F.2d 1054, 1056 (6th Cir. 1983), that "an agency's violation of its procedural rules will not result in reversible error absent a showing that the claimant has been prejudiced on the merits or deprived of substantial rights because of the agency's procedural lapses" (emphasis added). A procedural right must generally be understood as "substantial" in the context of this statement when the regulation is intended to confer a procedural protection on the party invoking it. **The Supreme Court has recognized the distinction between regulations "intended primarily to confer important procedural benefits upon individuals" and regulations "adopted for the orderly transaction of business before [the agency]."** *Am. Farm Lines v. Black Ball Freight Serv.*, 397 U.S. 532, 538-39 (1970) (internal quotation marks omitted). In the former case, the regulation bestows a "substantial right" on parties

> before the agency, and "it is incumbent upon agencies to follow their own procedures . . . even where the internal procedures are possibly more rigorous than otherwise would be required." *Morton v. Ruiz*, 415 U.S. 199, 235 (1974); see also *Vitarelli v. Seaton*, 359 U.S. 535, 540 (1959); *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 267 (1954). In contrast, in the case of procedural rules "adopted for the orderly transaction of business," an agency has the discretion "to relax or modify its procedural rules" and such action "is not reviewable except upon a showing of substantial prejudice to the complaining party." *Am. Farm Lines*, 397 U.S. at 539 (quotation omitted). **Section 1527(d)(2) falls in the former category, creating an important procedural safeguard for claimants for disability benefits.** *Snell*, 177 F.3d at 134.(emphasis supplied)

It is noteworthy that the *Wilson* Court did not even consider the mandate of 42 USC 423(d)(5)(B). Certainly, if respondent cannot ignore her own regulations, she cannot ignore the directive of the U.S. Congress.

2. Whether the court of appeals erred in holding that this obligation can be shifted to claimants.

Moreover, in the instant cases the Fifth Circuit effectively delegated to the petitioners the obligation of developing information that would satisfy the ALJ's reservations or perceived inconsistencies, though 20 CFR 404.1512(e)(1) expressly states that respondent will undertake that task. This is inconsistent with the express holding of the Tenth Circuit in *Robinson v. Barnhart*, 366 F.3d 1078 (10th Cir. 2004):

> [32] Third, the ALJ's statement that Dr. Baca's records did not give a reason for his opinion that claimant is unable to work triggered the ALJ's duty to seek further development of the record before rejecting the opinion. If evidence from the claimant's treating doctor is

> inadequate to determine if the claimant is disabled, an ALJ is required to recontact a medical source, including a treating physician, to determine if additional needed information is readily available. See 20 C.F.R. §§§§ 404.1512(e)(1) and 416.912(e)(1) ("We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques."); see also *McGoffin*, 288 F.3d at 1252 (holding ALJ had obligation to recontact treating physician if validity of his report open to question). **The responsibility to see that this duty is fulfilled belongs entirely to the ALJ; it is not part of the claimant's burden.** *White v. Barnhart*, 287 F.3d 903, 908 (10th Cir. 2001). If the ALJ concluded that Dr. Baca failed to provide sufficient support for his conclusions about claimant's mental limitations, the severity of those limitations, the effect of those limitations on her ability to work, or the effect of prescribed medications on her ability to work, he should have contacted Dr. Baca for clarification of his opinion before rejecting it. The ALJ did not do so.(emphasis supplied)

The decision in *White v. Barnhart* is at least as direct in finding that the respondent cannot shift her burden to the plaintiffs, stating:

> Ms. White claims that the ALJ should have recontacted Dr. Fanning to obtain a more detailed medical examination and disability assessment. The Commissioner responds by blaming Ms. White for failing to carry out her "responsibility to bring forth evidence related to the disability that she claims." Appellee's Br. at 25. If by this accusation the

> Commissioner suggests that the ALJ's duty to recontact a treating physician is contingent on the some further act by the claimant, the Commissioner is wrong. The Commissioner, under the governing regulations, must recontact a treating physician when the information the doctor provides is "inadequate . . . to determine whether you [the claimant] are disabled." 20 C. F. R. §§ 416.912(e). The regulations do not burden the claimant with any additional obligation in this regard once the record is deemed "inadequate."

In the instant cases, the respondent found the evidence so "inadequate" as to require consultative examinations. She should first have recontacted the treating physician(s) to attempt to reconcile perceived inconsistencies or inadequacies.

CONCLUSION

The United States Congress understands the importance of Social Security Disability claims. For these unfortunate claimants, the decision determines whether they will be able to relieve the burden on their families with a minimal existence and whether they will be able to have their medical needs properly cared for. Because of their numbers, the decision making system must be somewhat informal. Thus, *Lidy v. Sullivan*, 911 F.2d 1075 (5th Cir. 1990) notwithstanding, the few requests for subpoenas of physicians filed by undersigned counsel have been uniformly refused. Moreover, Social Security disability claimants are notoriously unable to pay the fees of expert testimony, so that treating physicians are not available for examination by the ALJ.

Accordingly, if an ALJ should have questions of the treating physician, he would be constrained to call him (even doctors talk to judges) or send written questions. The regulations now require it, even when the ALJ is reluctant. If there are perceived deficiencies in the opinions of treating physicians, though it may be an additional burden to the ALJ to contact the treating physician by telephone or by mail, it is one which must be borne. One cannot simply say, "It would have been too much trouble to ask the treating physician for an explanation."

It is impractical to ask of claimants, especially unrepresented claimants, that they divine the questions that would satisfy the reservations of the ALJ and solicit the treating physicians to answer them. Claimants can barely convince physicians to execute medical assessment forms. Physicians are much less likely to ignore inquiries from federal judges.

The total abandonment of the implementing regulations and the provisions of 42 USC 423(d)(5)(B) constitutes much more than a bare lack of "procedural perfection." It constitutes a flagrant violation of a claimant's right to have his or her

treating physician provide the evidence on which a determination of eligibility for disability benefits is based, a right conferred by the same body that drafted the Social Security Act, the U. S. Congress. Failure to reverse the decision below would tell Congress that they can pass all the laws regarding a determination of disability they wish to pass, the Social Security Administration will ignore those laws, seek and rely upon whatever opinions it wishes, usually from "key providers" (See 20 CFR 404.1519s(e)), and do so with impunity, secure in the knowledge that the judiciary will find that the "harmless error" or lack of "procedural perfection" does not invalidate the determination.

If the courts will not enforce the intent of Congress, who will?

The petition for a writ of certiorari should be granted.

Respectfully submitted,

PAUL BRIAN SPURLOCK
Attorney for Petitioners
DATE: July 4, 2005

Supreme Court, U.S.
FILED
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No. _____ OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

MAXANN C. FINK,

Petitioner

v.

JO ANN B. BARNHART,
COMMISSIONER OF SOCIAL SECURITY

Respondent

c/w

IDA J. ROCHESTER,

Petitioner

v.

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Respondent

On Petition For Writ of Certiorari
To the Fifth Circuit Court of Appeals

APPENDICES TO PETITION FOR WRIT OF CERTIORARI

PAUL BRIAN SPURLOCK
Counsel for Petitioners
DISABILITY LAW CENTER, INC.
500 HAGAN AVENUE
NEW ORLEANS, LA 70119
TELEPHONE: (504) 822-2224

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PAUL BRIAN SPURLOCK
Counsel for Petitioners
DISABILITY LAW CENTER, INC.
500 HAGAN AVENUE
NEW ORLEANS, LA 70119
TELEPHONE: (504) 822-2224

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APPENDIX A:

SOCIAL SECURITY ADMINISTRATION
Office of Hearings and Appeals
DECISION

IN THE CASE OF CLAIM FOR

Period of Disability,
Disability Insurance Benefits, &
Supplemental Security Income

MAXANN C. FINK 436-94-1596
(Wage Earner) (Social Security Number)

Claimant filed concurrent applications for disability insurance benefits and supplemental security income with a protective filing date of July 22, 1998. (Ex 6D/1). Following denial of the claims initially and on reconsideration, she filed a timely request for hearing. She testified at the hearing, which was held in Metairie, Louisiana on July 26, 2000. She was represented by an attorney, Clydia Davenport. Thomas Meunier testified as vocational expert. Leon Weisberg testified as medical expert.

Claimant is 44 years old. She has a GED and has not worked in at least the past 15 years. She testified that she last worked in 1982 and received worker's compensation benefits for several years thereafter. In her application documents, she alleged disability since September 19, 1980 due to three ruptured discs in her back and two ruptured discs in her neck.

There is no evidence of substantial gainful activity after the alleged onset date. Claimant's wage records reflect only minimal earnings in 1981 and 1991. (Ex. 8D)

Claimant's insured status under the Act expired on June

30, 1986. Therefore, to be entitled to benefits on her claim for disability insurance benefits under Title II of the Act, disability must be established on or before June 30, 1986.

The medical evidence indicates that Claimant was under the treatment of Dr. Gessner (orthopedist) from 1981 to December 1986. On January 9, 1981, she reported that she sustained an injury to her low back a few months earlier. According to Dr. Gessner, x-rays showed spina bifida and a slight degree of spondylolisthesis at L5-S1. Examination indicated positive straight leg raising on the right at 45 degrees. By February 1, 1983, Claimant was complaining of intermittent low back pain and leg pain which was worse on the left. She had mild spasm on examination of the low back. Conservative treatment was recommended. Dr. Gessner commented that, if Claimant's pain got to the point where she needed medication on a routine basis, he would have to proceed with surgery (and she did not subsequently undergo any back surgery). Dr. Gessner did not think that Claimant stated that Claimant was not capable of returning to her "usual" work (which required heavy exertion (Ex. 1E/6) However, he believed that she could perform "sedentary" secretarial-type work. On Marc 15, 1983, Claimant complained of low back discomfort. The diagnostic impression was herniated disc and slight spondylolisthesis (the previously noted spina bifida was no longer noted and was apparently not thought to be significant). From March through December 1983, Claimant's complaints included weakness in the left leg, pain in the right leg, and numbness in both legs; however, neurological examination remained intact. The clinical findings were basically limited to mild muscle spasm and positive straight leg raise. She was continued on Soma. Dr. Gessner reiterated that she could do sedentary-type work. The diagnostic impression became only herniated disc (indicating that the slight spondylolisthesis was not thought to be significant). In March 1984, Dr. Gessner started Claimant on physiotherapy (heat, massage,

ultrasound). On July 24, 1984, she was complaining of discomfort which was not to the point where surgery was indicated. Examination on November 14, 1984 indicated mild spasm. In January 1985, she was taken off all medication due to pregnancy. On May 7, 1985, Dr. Gessner wrote that Claimant was "disabled from work activity" secondary to her low back, but provided no supportive findings and did not say whether he was referring to all work or only her usual work. (If he no longer believed that she could perform sedentary-type work, his records do not provide any reason for the change in opinion.) On July 3, 1985, Claimant complained of back pain and numbness in hands. Dr. Gessner's records do not reflect prior or subsequent complaints regarding the hands. On February 19, 1986, Claimant complained of increased pain, but there was no mention of any clinical findings. On June 25, 1986, Claimant complained of right-sided neck, shoulder, arm, and leg pain after a motor vehicle accident. The impression was cervical strain and contusion. On follow-up on July 8, 1986, she was said to be improved. On December 16, 1986, Dr. Gessner said that her pain was "controlled" with Soma. She complained of some weakness in her legs, but neurological examination was intact and she demonstrated good dorsiflexion on examination. (Exs.11F, 13F).

There is no indication that Dr. Gessner examined Claimant after December 1986. An update of his records as of April 2000 indicated no records after December 1986. (Ex. 13F). Claimant testified that she stopped seeing Dr. Gessner when her worker's compensation claim was settled.

Lumbosacral CT on January 8, 1987 showed no evidence of bulging or herniation. MRI on March 16, 1987 showed degenerative disc changes with minimal bulging at L5-S1. (Ex. 1F).

Claimant was admitted to Chalmette Medical Center from January 23 to 25, 1989 for evaluation low back pain

complaints. She said she had sustained an injury half a year earlier. She complained of a constant dull ache in her low back with radiation down the right lower extremity to the foot. Sensory examination was normal in the lower extremities. Motor examination indicated approximately 4+/5 strength throughout. Lumbar myelogram/CT showed mild bulging of the lower 2 lumbar discs. Surgical treatment was not thought to be indicated. The impression was low back syndrome. (Ex. 2F).

Claimant was evaluated at Chalmette Medical Center on May 28, 1990 for complaints of right hip and shoulder pain after being involved in a motor vehicle accident. X-rays were normal. (Ex. 3F).

There is no evidence to indicate that Claimant sought or received any significant medical treatment for back complaints from January 1989 to January 1994, a period of 5 years.

Claimant was initially examined by Dr. Landry (orthopedist) on January 7, 1994. She reported that she injured her neck in a motor vehicle accident in 1992. She had complaints of intermittent left-sided neck pain and shoulder pain, and intermittent "pins and needles" in the left upper extremity. Examination indicated some tenderness in the left trapezius area. Range of motion was normal in the neck. There was no spasm. Neurological examination of the upper extremities was normal. X-rays of the cervical spine were normal. She also reported a history of "three damaged discs" in her low back, but there was no indication of specific low back complaints or examination of the low back at that time. Cervical MRI on January 13, 1994 was said to show a small disc herniation at C6-7. On March 28, 1994, Claimant complained of left-sided neck pain with intermittent radiation into the left upper extremity. On examination there was no tenderness or spasm. Cervical range of motion was normal except for slight limitation of rotation to the left. There was no indication of neurological abnormality in the upper extremities

except for diffuse weakness on the left. On July 27, 1994, Dr. Landry noted that EMGs/NCS on July 20, 1994 had shown no abnormalities. Claimant was not interested in surgery, and it was noted that she was involved in litigation. (Ex. 4F).

Claimant underwent uterine surgery (D&C) at Washington/St. Tammany Medical Center on March 27, 1996. Her complaints indicated two heavy menstrual periods per month over the previous year. A detailed pre-surgical history and physical indicated that she was well nourished and in no acute distress. Her past medical history indicated nothing about problems with her neck, back, or hands. There was no indication that she considered herself disabled from working. She described her occupation as "housewife". She was said to be taking Pepcid for heartburn. She did not report any pain medication. (Ex. 5F).

Claimant returned to Dr. Landry on May 3, 1996. She complained of neck pain and headaches with intermittent pain, numbness, and tingling in the upper extremities (more on the left). She denied any change over the past two years and said that her symptoms were not bad enough to want surgery. Examination indicated some tenderness in the neck, but no spasm. On that date, Dr. Landry also examined Claimant's back. (During the previous two years of treatment there had apparently been no significant complaints or examination relating to the back). The examination indicated low back tenderness, but no spasm. She was able to flex forward to 60 degrees. Reflex and sensory examinations were normal. The impression was cervical and lumbar disc disease. Soma was prescribed "as needed". (Ex. 4F)

After continuing complaints of irregular menstrual bleeding, Claimant underwent total hysterectomy in May 1996. A detailed pre-surgical history and physical reflects some complaints related to sinus trouble and heartburn. However, there is absolutely no mention of neck, back, or hand problems,

or any indication that she considered herself physically disabled. She again reported her occupation as housewife. (Ex. 5F).

Claimant returned to Dr. Landry on January 17, 1997. Neurovascular examination of the upper extremities was intact. Straight leg raising was said to be positive. (Ex. 4F).

An upper GI series on March 14, 1997 indicated a small sliding hiatal hernia with minimal reflux and active superficial peptic ulcer disease.

Claimant was hospitalized from July 15 to 16, 1997 for evaluation of chest pain. On admission, she reported a recent episode of chest tightness. She reported that she was otherwise generally well (again clearly indicating that she did not consider herself disabled from working). She reported a history "many years ago" of "disc collapse", but her current complaints included only some occasional neck pain and stiffness. She did not report that she was taking any pain medication. She did not complain of problems with her back or hands. Her activities of daily living were said to be "good and normal" (again clearly indicating that she did not consider herself disabled). Examination of the extremities was said to be within normal limits, and neurological examination was entirely intact. EKG showed some abnormalities. She was scheduled for cardiac follow-up to rule out unstable angina (see below). (Ex. 5F).

Claimant returned to Dr. Landry on July 18, 1997. He noted that her litigation had ended. She complained of continuing symptoms, but said that she would gradually increase her activities. (Ex. 4F).

A stress test on August 4, 1997 was negative for cardiac ischemia. (Ex. 6F).

On November 20, 1997, Claimant was seen at Washington/St. Tammany hospital with a rib contusion. At that time, her only medication was said to be Pepcid (no pain medication). (Ex. 5F).

Claimant returned to Dr. Landry on April 22, 1998. She complained that her neck bothered her with "occasional" stiffness and tension headaches. She complained of "constant" low back pain, but said that she could live with it. She complained of "occasional" numbness and tingling in the lower extremities with long sitting. That complaint was said to involve most of the left leg and the right foot. She said that she was trying to walk a mile a day. (Ex. 4F).

At the request of the Administration, Claimant was examined by Dr. Keppel (orthopedic surgeon) on November 2, 1998. Dr. Keppel noted the history of C6-7 disc herniation reflected in Dr. Landry's records. Claimant complained of some discomfort in her neck. There was no evidence of muscle spasm, atrophy, or motor weakness, and her reflexes were intact. Neurological examination was normal except for a complaint of numbness in the entire right hand. Tinel and Phalen signs were positive on the right.

Dr. Keppel thought the right hand complaint might be secondary to carpal syndrome of the right hand and wrist. Claimant complained of low back pain; however, there was "very little in the way of neurologic findings". She had subjective weakness in all motor groups, but Dr. Keppel was not sure if her effort was good. Her gait was normal and she demonstrated forward flexion to 80 degrees. There was no atrophy, and sensory examination was intact. X-rays of the cervical and lumbar spine were essentially negative. Dr. Keppel concluded that Claimant should be able to perform sedentary and light duty activities. (Ex. 7F).

Claimant returned to Dr. Landry on April 26, 1999 for follow-up of "chronic neck and low back pain". She stated that her back had bothered her "a lot" during the previous year because she was lifting her invalid father. Examination indicated lumbar tenderness, but no spasm. Straight leg raising was 90 degrees bilaterally. Examination of the neck indicated

normal curvature, no spasm, and full motion. Examination of the extremities indicated intact and symmetrical reflexes. Despite the clear and apparent lack of positive findings, Dr. Landry stated that Claimant was "disabled from gainful employment".

On October 25, 1999, Claimant was seen by Dr. Landry for follow-up on her neck and back. She complained of increased tingling in the right hand over the previous 6 weeks and right hand weakness with repetitive use. Examination of the hand now indicated negative Tinel's and Phalen's signs. Sensation was said to be diminished in the right middle finger tip. Dr. Landry's impression included cervical and lumbar disc herniation "by history," and he further concluded that she might have carpal tunnel syndrome on the right. (Ex. 12F) L/Clearly, there was not even a definitive diagnosis that Dr. Landry could base on his clinical findings and results of diagnostic studies.

At the request of Claimant's attorney, Dr. Landry completed a form on October 25, 1999. He checked the following items on the form as being present: pain, significant limitation of spinal movement, sensory loss, reduced grip strength bilaterally, numbness and cramping in the right hand with use, low back pain with sitting for protracted periods, and a need to recline periodically for relief of pain. He indicated that the following were not present: muscle spasm, appropriate radicular distribution of significant motor loss with muscle weakness, and reflex loss. He believed that Claimant was able to lift 20 pounds at a time and stand/walk for 2 hours out of an 8 hour day with breaks. He did not believe that she could sit for 6 hours out of an 8 hour day or alternate standing and sitting for 8 hours without walking about or reclining. Claimant's diagnoses were said to/lumbar and C6-7 disc herniation "by history" and possible carpal tunnel syndrome. (Ex. 10F). Again, the impression does indicate any definitive diagnosis.

Dr. Gessner completed the same form provided by

Claimant's attorney. The form was presumably completed shortly before it was received by the Administration on November 8, 1999. By that time, Dr. Gessner had not treated Claimant in nearly 13 years. He indicated that, as of June 30, 1986 (the date she was last insured under the Act), Claimant had the following: bilateral numbness in her hands with any significant use, reduced grip strength bilaterally, "pins and needles" and cramping with writing for more than 10 minutes, low back pain with sitting for protracted periods, and a need to recline periodically on most days to relieve pain. Dr. Gessner indicated that Claimant could lift only 10 pounds at a time and could not sit or stand/walk for even 2 hours out of an 8 hour day. Again, it is to be noted that these symptoms and limitations were merely checked by Dr. Gessner on the form provided by the attorney. The diagnosis was said to be chronic low back pain and cervical disc disease. (Ex. 9F).

On March 24, 2000, Claimant was examined by Dr. Laborde (an associate of Dr. Landry). She complained of neck pain radiating into her right hand with numbness, but said that the pain and numbness had improved. She demonstrated good range of motion in her neck and was neurologically intact. Claimant said that she would obtain x-rays at Charity Hospital (but there is no indication that she did so). (Ex. 12F).

At the hearing, Dr. Weisberg's testimony indicated as follows: The objective medical evidence does not support the diagnoses or degree of limitation set forth by either Dr. Gessner or Dr. Landry. The medical records support a soft tissue musculoskeletal impairment at best. There is no evidence of radiculopathy. There is no evidence of motor disability related to the right carpal tunnel syndrome. There is no significant indication of anemia related to Claimant's history of irregular uterine bleeding. The degree of pain alleged by Claimant is not supported by the clinical findings or objective studies. There is almost nothing in the way of clinical findings noted by either